SOCIAL DIMENSIONS OF HEALTH CARE AND HEALTH POLICY

South East Asia Regional Seminar

A Report

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SOUTH EAST ASIA SEMINAR

SOCIAL DIMENSIONS OF HEALTH CARE AND HEALTH POLICY

A Report

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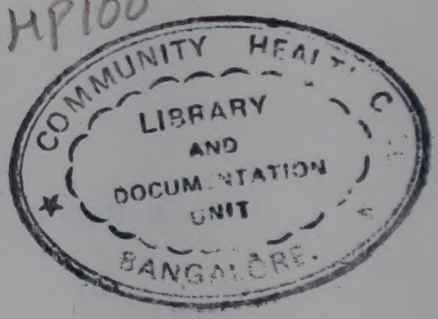

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SOCIAL DIMENSIONS REPORT

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Introduction

The Ist South East Asia Regional Seminar on Social Dimensions of Health Care and Health Policy was held at the National Institute of Health and Family Welfare in New Delhi from March 16-18, 1992. This Seminar brought together social and medical scientists, practitioners and administrators for a discussion of emerging issues in the area of health and social policy. This was, perhaps, the first such regional meeting in South East Asia convened by a body other than WHO. The National Institute of Health and Family Welfare (NIHFW) co-hosted the Seminar with the Ford Foundation, Indian Council of Medical Research (ICMR), Indian Council of Social Science Research (ICSSR), Social Science and Medicine (UK), WHO and UNICEF. NIHFW had earlier in August 1991 organised a national level seminar on the same subject. That exercise had given some insights into health policy imperatives in relation to various social issues in India. In the same vein, the present Seminar was an attempt to put into focus the social dimensions of health programmes and policies in the countries of the region, and to draw common lessons from them.

The Sout East Asian countries have made a commitment to promote Health for All by 2000 A.D., and adopted primary health care scheme as the principle strategy for promoting the health status of their peoples. The policy framework of HFA takes cognisance of the fact that health is intimately influenced by the society's valuesystems, cultural and philosophical ethos, and the existing socio-political institutions. The attention of planners, administrators, medical professionals needs to be drawn to this reality. The imperatives of a comprehensive outlook on health, which draws on an assessment of utilisation of health services and of health-seeking behaviour, calls for an integration of social dimensions of health behaviour into an overall framework of health planning, implementation and evaluation strategies. This well-conceived approach calls for not only re-allocation of resources but also identification of socio-political constraints which are acting as bottlenecks in implementing policies.

Unfortunately, the policy initiatives taken in vital areas of maternal and child health, nutrition, environmental sanitation, water supply and urban health services are rather limited. Despite the existence of some strategy of national health services in every country, the patterns adopted and the extent of their implementation vary considerably among different countries. Inspite of explicit intentions of providing for comprehensive planning and implementation strategies, health planning and programming have a dominant bias for medical services. Apparently, the implementation of health policy calls for critical changes to be brought about in the value-orientation of health care providers as much, if not more, as of the recipients. There has to be a change in focus from the individual to the group within the wider socio-physical

environment which is the source of disease and poor health practices in Asian countries. These sociological dimensions have not received adequate attention so far from the planners and medical scientists of the region.

Meanwhile, societal processes of certain kinds are becoming stronger and there are some alarming trends, such as privatisation of health care, making such care even less accessible to the weaker sections of society than before. A luxury sector in health care has made its appearance in the region. There is a distortion of both social resources and values. Women's and children's health demands closer attention and prioritization in evolving health infrastructure in such distorted situations. Further, because of the failures in the development processes, a gradual change is emerging from a narrowly defined growth-oriented development model towards concern for improvement in the quality of life of people. These social pressures for bridging the gap between social development strategies and the existing health delivery care systems call for a fresh look at the existing health care delivery systems.

The Asian region is also facing an unprecedental growth of urban areas and urban population. This signifies a deep and vast social ferment, affecting the quality of life; it puts enormous pressure on amenities and services, contributes to continuous degradation of environment and general deterioration of the living standards. The ever recurring threats of malnutrition, epidemics and housing shortages continue to baffle health administrators. The coexistence of diseases of affluence and diseases of unimaginable poverty are the challenge of today. These dimensions of urban health are yet to be understood in a proper perspective.

A new area of concern that needs attention is AIDS. In the Asian region the problem appears to be behavioural in nature and needs to be tackled primarily at that level. The behavioural dimensions responsible for its transmission, infection and subsequent spread have not yet been fully understood in the context of varying socio-cultural dimensions. Setting up of an Asian Monitoring Cell for identifying the areas or the sections of population particularly vulnerable to this virus, and for assessing the effectiveness of the measures already taken to provide protection to them needs to be considered seriously and urgently.

It is against this background that the present South East Asian Regional Seminar was organized in New Delhi (India) with the purpose of highlighting the relevance and role of social sciences in evolving viable health systems in the countries of the region. That the whole range of social sciences (including health economics, medical anthropology and sociology, medical geography, and medical psychology) ought to be pressed into service has been an objective promoted over the last two decades by Social Science and Medicine and many international and national organizations. The journal took the initiative in the

organization of regional conferences beginning with a conference in Africa, in 1990, followed by another in Latin America in 1991. The present Seminar was thus the third such gathering and the initial suggestion for it came from the same source and was endorsed by the National Institute of Health and Family Welfare (New Delhi) and then by the Ford Foundation, ICSSR, and other co-sponsoring agencies.

The Seminar aimed at identifying some critical areas of concern and indicating strategies for community participation-based and inter - and intra-sectoral coordinated mechanisms in health care delivery systems. It sought to emphasise group strategies for corrective action and aimed at providing a new impetus to strategies of bringing about an effective tie-up between social sciences and health systems. Finally, it sought to explore ways and means of promoting information flows and sharing experience.

OBJECTIVES

OVERALL OBJECTIVE

To provide a common platform for health administrators, social scientists and medical professionals, to discuss the issues of health care and health policy in relation to the implementation of the Health for All strategies in the South East Asian region, and to explore the scope of social science perspectives on the same.

To develop channels of communication for future contact and collaboration between the concerned institutions in the region pursuing research on the contribution of social sciences to health.

THEMES

The Seminar covered several issues that would forge stronger links between social sciences and health systems. It took up following broad issues for discussion:

1. Mother and child health care.
2. Urban health, issues and perspectives.
3. Interface between public, private voluntary agencies in the field of health care.
4. AIDS - Social implications and the future policy.

While presenting papers on the above themes; the participants were expected to dwell on status of policy perspectives and implementation strategies in their respective countries. The deliberations were to focus on the research and training inputs being given to promote the tie-up between social

science inputs and health system development in their countries. The Seminar was expected to promote institutional networking and contacts for the smooth flow of information.

The Seminar was attended by social scientists, health administrators and health professionals working in the areas of health and family welfare from Bangladesh, Indonesia, India, Malaysia, Nepal, Philippines, Singapore, Sri Lanka and Thailand (See Appendix-I).

THE INAUGURAL SESSION

The Chief Guest at the inaugural ceremony was Mr. K.K. Mathur, Secretary, Family Welfare, Ministry of Health and Family Welfare. Dr. J.P. Gupta, Director of NIHFW welcomed the delegates and the Chief Guest. He outlined the scope of the Seminar. Prof. S.C. Dube, an eminent sociologist, delivered the inaugural address. Prof. P.L. Trakroo gave the vote of thanks.

INAUGURAL ADDRESS

In recognition of the importance of health for human well being and development, an ambitious plan of Health for All has been initiated under the auspices of the UN and its associated organizations. The magnitude of the problem is mind-boggling, not so much in terms of the numbers to be brought under the programme, but in terms of the many intangibles and imponderables underlying the complex interplay of social and psychological factors in diverse cultural settings. The nexus between health and culture is important: to ignore the social dimensions of health is like jumping in the dark in an alien and uncharted territory. Such a mindless adventure must be avoided.

It is necessary to locate the discourse on health within the wider discourse on development. For this a quick look at the changing global scenario and related pragmatic shifts in the thinking on development is essential. The new contexts have a significant bearing on policies governing health care.

The world today is not what it was a decade back, but its configurations still have several enigmatic aspects. There are some signs of hope: the danger of a nuclear holocaust has receded somewhat, and if things go well cold war between the super powers may become an unpleasant memory of the past. However, prospects of a stable world order and global peace still remain dim. No mechanisms have been evolved to hold in check regional conflicts that erupt from time to time and have the fury and destructive potential of short duration wars. The quest for peace, thus, remains elusive. And peace cannot be understood only as absence of war. The distribution and consumption of resources is uneven; a few highly industrialized countries corner a disproportionately large share for themselves and the less developed countries are experiencing a nightmare of frustrations. Pervasive discontent and disaffection have resulted in a credibility gap and a crisis of legitimacy for the State system. The State finds itself unable to attend even small development problems that concern the different strata of society, particularly the disadvantaged poor.

The dominant paradigms of development have undergone major shifts. Some important newer perspectives which have come into being are "human-centred development", "basic needs", and "quality of life". Health has to be seen as a basic need and an

essential component of the quality of life. If health is dealt with gingerly in development planning, and treated as an expensive overhead, the attainment of several important development objectives in other related areas may be affected. Health, for example, has a direct bearing on productivity. In the same way, health and education have to be understood as interacting and mutually reinforcing sub-systems. Education creates a heightened awareness of health and health care. In this context, "health" and "health care" have to be defined broadly, for they include, besides preventive and curative medicine, nutrition and provision of potable water, environmental sanitation, social hygiene, rest and recreation, and much else.

Health care packages have to be culturally contextualized. What makes for good health is as much a matter of scientific understanding of nutrition, hygiene, and causation of disease as of cultural orientation to health and illness. In the Indian context some diseases may be attributed to one's errors of commission and omission in past lives, some to divine wrath, some to supernatural malevolence, and some to natural causes. Even physicians and surgeons trained in modern medicine carry some shreds of these beliefs. The care of those suffering from leprosy, tuberculosis, epilepsy, hysteria, jaundice, measles, chickenpox, smallpox, and many similar diseases is culturally conditioned. Can the prevalent notions be altered without a direct confrontation with culture?

As important as the health care package is the health delivery system. Do messages of preventive and social medicine reach the common people? How do they manage the culture-rooted reactions which such messages produce? Is the provision for curative medicine adequate? Every failure on this front leads to return to common beliefs and fatalism.

A sound development policy has to adopt a holistic view of human needs. Health objectives have to be enmeshed and harmonized with the entire range of development goals - raising productivity and GNP, food security, quality of environment, education, housing, and so forth. Weakness in any one is likely to have an adverse effect on all others.

The key issues in the area of mother and child care hinge on the explicit and implicit assumptions regarding the status and roles of women in society. Many more female children die of callous neglect and deliberate indifference. According to a dependable estimate, in India 300,000 more girls than boys die in infancy. The nutritional profile of women compares unfavourably with that of men in a high proportion of Indian families. Discrimination extends even to education and thus to economic opportunities. These factors inhibit their productive participation in wider social and economic spheres and blunt the articulation of their creative potential.

A programme of supplementary nutrition for the pregnant mothers will have to be devised and implemented. Cultural factors

come in the way. Will it do if raw ingredients from a carefully worked out inventory are supplied to the beneficiary? For one can count on the self-sacrificing Indian and Asian woman to feed them to her children and husband. Let us pause and think how we can make these programmes work.

Rapid urbanization is a feature as well as an outcome of modernization. Megacities, and indeed all large cities, in the developing countries have to face the problem of squatters and pavement dwellers. Lack of hygiene and malnutrition brings in a number of ailments and diseases. Sexually transmitted diseases are common. In India, outbreak of gastro-enteritis is an annual feature in squatter colonies.

In the health care field, "privatization" is not a new phenomenon. It has always been there in one form or the other, often in several forms. What has highlighted the privatization factor is the setting up of five star medical facilities with hightech diagnostic aids. But these evidently serve only those who have the wherewithal to take advantage of them. Private medicare is there to stay; the trend cannot be reversed. But its commercialization has to be held in check, if left unregulated can lead to unethical over-medication and non-essential surgery. Those with relatively modest resources also need clean and efficient hospitalization at affordable prices.

The magic of the market place has worked to the detriment of the sick globally, but the less developed countries feel the pinch all the more. Drugs banned and discarded by the advanced countries as injurious are off-loaded on them. Markets are saturated with a wide range of restoratives, tonics, and vitalizers, which are all medicinally useless.

The dreaded AIDS has caused a global scare. Its spread can be attributed to the breakdown of the norms of sexual ethics and the prevalence of an ethos of permissiveness in the society. But we cannot write if off as divine retribution for breach of sacred moral codes, as innocent lives are also affected by it through transfusion of contaminated blood or use of infected hypodermic needless.

So long as poverty and illiteracy persist only limited gains can be registered in the field of health care. The accent has to be on health education and preventive medicine, including immunization. For this youth power has to be energized and voluntary action groups activated. Barefoot doctors, inducted in a cavalier manner, can do more harm than good. The scheme of access to a smorgasbord of medical systems also has not worked well. Both need better conceptualization and implementation. The malaise of the medicare systems are known, but we have lacked the will to attempt radical therapy. Vested interests often block effective action. This forces us to make notional reforms and treat only some of the symptoms. The situation is too grim to permit such prevarication.

THEME 1: MOTHER AND CHILD HEALTH CARE

CHAIRMAN : **MS. RAMI CHHABRA (INDIA)**

RAPPORTEUR : **DR. S. BHATNAGAR (INDIA)**

Background Papers:

1. **Maternal and Child Health Care in India**

   - PROF. H.H. Simon (INDIA)

2. **MCH: An Appraisal of Lessons Learnt from Rural Areas of Bangladesh.**

   - DR. Md. Shafiqual Islam (Bangladesh)

3. **Strategies to Improve Accessibility of MCH and Family Welfare Services in Bangladesh: Experiences from the MCH-FP Extension Project.**

   - DR. Rushikesh M. Maru
   - DR. John G. Haaga (Bangladesh)

4. **Social Dimensions of Policy Implementation - A Tripartit Framework for Community - Based Maternal and Child Health Ca**

   - Dr. Vijay Kochar (India)

5. **Women's Reproductive Health: Research Needs and Priorities for Developing Countries.**

   - Dr. Saroj Pachauri (Ford Foundation) India

6. **Mothers and Children: Consumer Perspective on Health Policy and Health Care.**

   - Ms. Shila Rani Kaur (Malasiya)

7. **Health System in Indonesia**

   - Dr. Yilfita Raharjo (Indonesia)

In India children below 14 years and women in the reproductive age (15-44 years) comprise about 63 per cent of total population. The MCH programme in India aims at promoting the health of women in the reproductive age group and at improving the survival and health status of expectant mothers and children.

Situational analysis regarding current status of maternal and child health, the socio-cultural and other allied factors which have a bearing on health system availability and utilisation of health care services was discussed in detail in the paper on **`Maternal and Child Health Care in India'.**

There is a close nexus between social and cultural factors and the status of a woman. The complete dependence of younger women on men, a wide gap of age between husband and wife, and lack of access to the outside world make it difficult for women to make decisions regarding number of children and when they would like to have them. Moreover, early marriage increases their period of exposure to the risk of pregnancy. Confronted with insecure future which probably becomes more unstable when her husband dies, a women undoubtely sees children, especially sons, as a potential source of security, both economically and socially.

Social and economic conditions, levels of medical technology and their availability play an important role in the efforts to improve living standards and reduce, in particular, the mortality of infants, children and mothers. Social and economic policies and family health policies should be mutually supportive. Many of the adverse biological and physiological conditions for child-bearing can be compensated by such circumstances which allow for health care of high quality, education, good nutrition, status of women and good nutritional status of children.

The success story of the MCH and family planning project undertaken in three districts of Bangladesh was recounted in the paper on **'Maternal and Child Health : An Appraisal of Lessons learnt from Rural Areas of Bangladesh'.** The data from ICDDR-B project (International Centre for Diarrhoeal Diseases Research) underway in three districts of Sirajganj, Noapara and Jessore has revealed facts about introducing flexibility in programme implementation and work schedule of the workers. In the two experimental sub-divisions of the Matlab MCH-FP Extension project, it came to the fore that pre-planned monthly work schedule of family welfare assistants (FWAs) could be relatively manipulated easily to improve the duration and the frequency of programme contact with village women. It has been shown that with more time available to spend with women, the potential to improve the quality of services is enhanced. The early results of the extension project at Sirajganj, Noapara and Jessore have been encouraging and many critical impediments to success were identified and consequently the government initiated corrective measures and made necessary changes in the new five year development plan of Bangladesh. The Bangladesh Government has

been able and to revise its strategy for the family planning programme, learn from operations which have brought about comprehensive improvement in its performance. The Matlab and the MCH-FP Extension Project experience in Bangladesh provides evidence that service delivery strategies adopted in the project sites have resulted in significant improvements in the accessibility of MCH and family planning services, despite a poor, illiterate and conservative rural social context. The higher levels of contraceptive prevalence and decline in fertility are an index of the revised strategy of programme implementaion. The MCH-FP Extension Project experience demonstrates the feasibility of scaling up experimental small project service delivery and mangement innovations to a national public sector programme.

The main strategies which made possible higher levels of performance were:

1. Employment of female workers from local areas.

2. Increasing worker density to make the work areas manageable and to increase quantity and quality of worker-client contact.

3. Broadening method - choice through changing performance criteria from method-specific targets to CPR.

4. Decentralizing clinical services through training of female workers in delivery of injectables at the doorsteps of the clients and through mobile satellite clinics.

5. Improving quality of care through training, screening protocols, supervisory check-lists and monitoring.

6. Improving field management through worker-oriented MIS and problem-solving supervisory meetings.

These strategies can also be relevant to other social settings characterized by low socio-economic context and limited management capabilities. It is also important to point out that operations research and pilot projects have played a critical role in helping the Bangladesh Government to translate these strategies to large-scale field operations. The lesson for the researchers and policy makers is that it is worthwhile to collaborate and shed inhibitions of working together.

* A similar collaboration is needed between social scientists and medical practitioners in order to develop a 'critical mass of inter-disciplinary experience.' Formulation of such an approach would enhance the feasibility of all health policy, planning and implementation issues. Such a proposal was discussed in the paper on **'Social Dimensions of Policy Implementation: A Tripartite Frame-Work for Community Based Maternal and Child Health Care.** This alliance between social scientists and medical scientists has to come about through a process which can be

phrased as 'synthetic convergence'. Such radical changes in perceptions have to come about for achieving any modicum of success.

MCH programme in India can be refurbished on the basis of a synthetic model of tripartite community based MCH services. The model integrates community, government and non-government sectors in a single framework. But then much of the existing MCH programme would have to be re-designed in a new framework for any effective change. The MCH services would get built around health needs, perceptions and health problems of women and children: a kind of horizontal interlinkages rather than vertical top to bottom percolation of health measures. This model also envisages a system in which alternative therapies and folk medicines have a fair advantage of being recommended than being ostracized.

A process of backward mapping has to be initiated for the assessment of requirements and implications for operationalisation, decisions and actions for any new system to prevail. This would facilitate a sequential actions which are to be arranged in the time sequence known as scheduling. Once the 'backward mapping' is reasonably refined, the 'forward mapping' can start. This would entail careful analysis of the whole procedure of policy formulation and action therein to be undertaken at different Central and State levels and further down in the administrative heirarchy. 'Forward mapping' foresees the required decisions, actions and inputs that will have to flow from each level in order to ensure that policy guidelines are actually implemented as desired and expected.

* Much of the emphasis in redesigning MCH programme would revolve around a concerted and joint action among voluntary groups, especially women's groups, researchers and policy formulators. This was the main focus area in the paper entitled **Women's Reproductive Health: Research Needs and Priorities for Developing Countries.'** The high burden of reproductivity and morbidity that women in developing countries suffer is the outcome of poverty, malnutrition, infection, high fertility, low status and lack of access to health care. These determinants operate synergistically throughout the life cycle of poor, disadvantaged women resulting in high levels of mortality and morbidity. It would help to examine these multiple factors which impinge on women's health. Researchers must examine the bio-medical factor within varying socio-economic and cultural contexts to get valid answers. A combination of clinical, epidemiological and social science research methodologies is needed to obtain reliable data.

The concept of 'Lab to Land' current in the agricultural extension programme has to be considered in the area of health requirements also. This would pull down barriers between policy planners and researchers and make policies more meaningful and relevant. In addition, research should enable and empower women to better understand and articulate their health needs and to make informed choices. Moreover, policy debates should be

incorporated in the design and implementation of programmes to give an added thrust and direction.

* Major salient points that have emerged from IOCU (International Organisation of Consumer's Union's) experience in the baby foods and children's medicines issues are: the influence, impact and control that transnational corporations exert on consumers and their decision-making. These issues were discussed in the paper, **'Mothers and Children: consumer Perspective on Health Policy and Health Care.'**

Implementing the International code of Marketing of Breast-milk substitutes is a first step towards re-establishing a breast-feeding culture. There must be polictical commitment by governments to give effect to the principles and aims in code in its entirety. Political commitment entails not only implementing the International Code, but also taking on the responsibilities for monitoring of compliance with national measures, imposition of sanctions against manufacturers, making available health services supportive of breast-feeding, and educating and training health personnel on the Code.

IOCU is also concerned with the structure and operation of the drug industry, drug regulatory policies and physician prescribing practices. These factors assume greater significance when children are the recipients of services defined by these policies. Essential drug policies are especially important in developing countries with limited resources and should be a vital part of any national health policy. Concepts of essential drug use and rational drug prescribing should be introduced into medical curricula early and strengthened through out the curriculum to ensure that proper prescribing practices are observed by physicians.

Drug regulation and enforcement should be an important aspect of any national policy on drugs. Government control should be comprehensive and include a system of registering and licensing medicines; make available accurate and objective information to prescribers and consumers and ensure ethical promotion of drugs.

As in many developing countries the fruits of development remain concentrated in the top sections of the society, similarly much of the health programme is not made available to larger population. This aspect was brought out in the paper on **Health System in Indonesia.** In Indonesia, the primary vehicles for the service delivery of primary health care are the Puskesmas (Health Centre) and Posyandu (Health Post). While the number of health facilities has increased dramatically in the last decade, the actual number that is accessible to the population depends on many factors such as the distance from the service centre and the population density. The distance of the health centres also varies. Regrading the accessibility of the health posts only few have reached the target of 1 post for 100 children. While in urban Jakarta the target of establishing 3 health posts in every

(Administrative divisions) may be inappropraite, due to high ocio-economic heterogeneity of the urban neighbourhoods. The me differences can be found in the health seeking behaviour of e urban and the rural poor. The rural women visit nurse dwives for prenatal care but prefer TBAs for birth assistance. ile the urban poor prefers the help of nurse midwives for enatal as well as delivery. The common rural practice of ying for service in kind rather than cash should be taken into count when introducing new health delivery models.

In Indonesia, it is realized that an effort towards public-ivate partnership still requires further organisation. If this oject is not conducted in a manner which is sensitive to lower ector economic groups, it may increase the possible gap of equalities concerning access to health care. A committence to e goal of the National Health System - the optimum quality of fe for all citizens and self relaince-needs to be realized by l who are engaged in health care.

THEME-2

URBAN HEALTH SERVICES : ISSUES AND PERSPECTIVES

CHAIRMAN : **DR. N.S. DEODHAR**

RAPPORTEUR : **DR. S. BHATNAGAR**

Background Papers:-

1. **Implications of the Spatial Distribution of Traditional Chinese and Modern Medical Services in Singapore**

   - Dr. Ooi Giok Ling (Singapore)

2. **Health and Health-related Aspects of Poverty Alleviation : Some Policy Issues**

   - Dr. S.T. Hettige (Sri Lanka)

3. **Health Care of Urban Poor in Dhaka Slums**

   - Dr. Kirk Dearden and (Banglade
   - Dr. Ngudup Paljor

4. **Health of the Urban Poor in India**

   - Dr. P.L. Trakroo (India)

5. **Urban Health in Bangkok**

   - Dr. Santhat Sermsri (Thailand)

IVE PAPERS WERE PRESENTED FROM SINGAPORE, SRI LANKA, BANGLADESH, NDIA AND THAILAND IN THIS SESSION.

The first paper **'Implications of the Spatial Distribution of raditional Chinese and Modern Medical Services in Singapore'**, ighlighted the plural Health Care System in Singapore in which nly modern medicine receives State sponsorship. This reflects he reluctance of policy makers to reconcile the use of modern ith traditional systems of medicine which are utilized by the eople. Though 70-80% of Chinese ethnic population practices elf medication by buying traditional (herbal) medicines, yet the raditional system is handicapped by lack of government ecognition and infrastructural facilities. Nevertheless, it lourishes alongside with the modern health care system. Such a ituation has come about because of changed urban development olicy of decentralising the population by accommodating them in ublic housing estates and new towns. This measure takes care of bout 38% of population in Singapore. And among them the choice f self-medication, with possibilities of purchases at Chinese edicine shops, remains popular. This is because of the onvenience of their availability. However, if given the choice, hinese ethnic population may prefer to use the modern medicine. nfrastructural development has therefore contributed to the roliferation of medicine retailing in Singapore but has provided imited opportunities for expansion of institution - based edical care as provided by the free clinics.

Some findings of an on-going research project launched in 989 in Sri Lanka on Health related aspects of poverty were iscussed in the paper, **'Health and Health - related Aspects of overty Alleviation: Some Policy Issues'.** Under the project the onventional view of linkages between health and poverty is not reated as under two separate compartments. Instead, a symbiotic elationship between the two is highlighted and the factors nfluencing poverty and health are treated as being interrelated. nder this project longitudinal case studies are being conducted nd monitoring of 60 families is done. Hamlet-level studies on HC infrastructure and dietary and anthropometric surveys are eing conducted as part of the project. The reasons which revents the poor from higher status of health and well being ave also been diagnosed.

Some of the factors which emerged out of the study of these oor families suggest that they have (i) excessive health xpenditure, (ii) higher dependency ratio, (iii) prevalence of lcoholism and chronic illness, (iv) disability, (v) ssetlessness, (vi) seasonality of income, (vii) undesirable onsumption pattern, and (viii) inadequate primary health care ervices etc. The mid-term conclusion of this study are that the nterrelationship between poverty and health is a common henomenon. To augment availability of resources at the grass-oot level a horizontal and integrated approach from diverse gencies is necessary, and a multi-sectoral health package should e made available to the poor.

* Another health scheme which has shown good result is operational in Bangladesh. The paper **'Health Care of Urban Poor in Dhaka Slums'** discussed the strategy of effective implementation through link persons. The health care scheme is carried out with the help of women volunteers. The women volunteers were raised at the rate of 1 for 30-50 households and were given brief training and education for ORS in diarrhoea weaning foods, Vit. A for under-nutrition, education and referral for immunisation and family planning. It was ensured that volunteers were selected from local areas and who lived in the slum areas. The evaluation of the project concluded that lay women can be recruited and trained as volunteers, who in turn can provide services which no other government personnel can. Perhaps the biggest motivating factors for them to work was the prestige attached to the voluntary health work and the potential for subsequent employment. A similar experiment in recruiting local volunteers in Nepal has also shown good results. The scheme provides for social volunteers but no honorarium is given to them. The programme ensures that these volunteers are trained in the recent developments of health and health-related issues from time to time. The experiment with women volunteers has also been found useful in Thailand.

* The paper on **'Health of the Urban Poor in India'** analysed the life styles, sanitation and environmental conditions, social tensions and scarcity conditions under which the urban poor live. The health problems of urban areas can be conceived in term of 'affluence' and 'scarcity' both coexisting and presenting two different sets of cultures of the same habitat. Conditions of affluence bring in health problems of spread of non-communicable diseases like hypertension and other cardiovascular diseases. The 'scarcity phenomenon brings about diseases like T.B., Malaria and malnutrition. In most cities, there is no effort to augment the health care delivery system because municipal structures are weak and unconcerned. For ensuring an effective reach, it is necessary to revamp the elements of PHC, introduce large-scale medicare insurance schemes and regionalise health care plans. This multi-pronged approach would become effective if public health consciousness is created, not only among the general public but also more pronouncedly amongst political parties. Political Support would give sanction to moves which would support preventive and promotive health care.

The model on demographic patterns and environment in Thailand was presented in a paper **'Urban Health in Bangkok'**. The Health of the Urban Poor is affected by lack of adequate housing, water supply and sewage disposal which accebrates risk for communicable diseases. The rural migrants tend to bring with them their traditional and often restricted dietary customs. The data presented in the paper suggested higher rate of physical and mental sickness in slum dwellers, more so in females which further compounds the difficulties of adjustment that they have to make. The study recommended at multi-sectoral approach or provision of good housing, hospital facilities for urban poor.

The discussion on Urban Health raised questions about what ndicators should be identified for an area to be treated as an rban slum. Sensitisation of elite should be done towards the eeds of the slum dwellers and effective inter-sectoral programme or the slum people would bring about desired changes in the ealth profile of these people. The poor environmental conditions ersist because of high cost involved and misplaced priorities. he incongruity of government priorities which lack in any cost - nalysis benefit assessment is obvious from the care of the civic nd medical care conditions in the city of Pune. The cost of nfectious hepatitis treatment every year in Pune is Rs. 16/- er head while the cost of laying sewers all over the city is Rs. 5/-. Hence, it would be wise to invest in improving the living onditions of the urban poor than having a mypoic vision of reating health only as medication and building bigger hospitals.

THEME - 3

INTERFACE BETWEEN PRIVATE, VOLUNTARY AND GOVERNMENT HEALTH SERVICES

CHAIRMAN : **DR. SANTHAT SERMSRI (THAILAND)**

RAPPORTEUR : **DR. R.N. GUPTA (INDIA)**

1. **SOCIAL ACTION IN THE FIELD OF HEALTH CARE**

   - DR. N.S. DEODHAR (INDIA)

2. **A TIE-UP AMONG NGOs' VOLUNTARY AND GOVERNMENT SECTORS**

   - DR. HELLEN OHLIM

3. **SOCIAL DIMENSIONS OF HEALTH CARE AND HEALTH POLICY: A CASE OF LEPROSY CONTROL IN INDIA**

   - DR. R.K. MUTATKAR (INDIA)

4. **POLICY ISSUES FOR PRIVATIZATION**

   - DR. MEERA CHATTERJEE (INDIA)

Health facilities/services network in most of the developing countries orginate from the state but the impact of the private sector is no less and infact has more credibility with the people. Moreover, voluntary action in health has had a more worthwhile tenure which recommends setting up of linkages among private, voluntary and government sectors.

HIGHLIGHTS OF PAPERS

* It is stating the obvious that each aspect of life influences health status. However, the importance of health is not realized by the poor in remote rural areas till it is lost. In this context the paper. **Social Action in the Field of Health Care** dealt with the importance of social action, its understanding and involvement of the community. The private and voluntary agencies are well ahead of the Government health system and hence meaningful social action and interface between them are necessary.

* WHO has, as a policy matter, favoured supporting NGOs and their involvement in providing health care. There is a need for understanding health and health-related problems, the present role of NGOs and emerging new role in the prevention of HIV infection. The need for social mobilisation and strengthening women's leadership, so far a neglected area in policy planning, have a far more significance.

* The paper on **National Leprosy Eradication Programme (NLEP) of India** discussed two programme models. The first being the blue-print approach based on careful pre-planning which helps in the planned development and the other being learning process approach that emerges out of the interactions between the villagers and the programme personnel. The main purpose of these approaches is to use social science strategies and develop new norms and create appropriate social climate for involving the community in the prevention and treatment, as well as, rehabilitation of the leprosy patients.

* There is a co-existence but no interface in actuality between public and private sectors. Health is influenced by society's value system and the same is true for the public and private sectors. The Government's role in developing more realistic policy for health is important. In the context of the health system and policy formulation a proper perspective about their bearing on social set-up is required. For this, the role of social science research would be to steer the course of its research in this direction as well.

SALIENT POINTS OF THE SESSION

- The villagers spend more on health care as compared with the Government funding.

- The final decision in health care has to be taken by the community and hence the interface with it is important.

- There is an epidemiological dilemma that the spread of disease can be controlled by chemotherapy.

- There is lack of information and knowledge among the people. If the entire leprosy programme has been handed over to be voluntary organisations, the T.B. control programme can also be better managed by them.

- The TB programme had received setbacks because it has been managed as a medical programme and not as a social science programme.

- The NGOs lack the expertise in project formulation.

- The NGOs have had a rough going with the concerned State Governments than with the Central Government.

- It would be worthwhile to study the organisation and the role of NGOs in Asian countries with Buddhist background. The experience may prove rewarding.

- The autonomy, flexibility, professionalism, established outlets, regular and reliable services, relationship with the Government etc. were referred in the context of the FPA in Sri Lanka.

THEME - 4

AIDS - SOCIAL IMPLICATIONS AND THE FUTURE POLICY.

CHAIRMAN : Dr. S.P. Tripathi

RAPPORTEUR : Dr. S. Bhatnagar

EPIDEMIOLOGICAL ASPECTS OF AIDS

- DR.PATNAIK (INDIA)

THE ROLE OF SOCIAL SCIENTISTS IN THE AIDS PANDEMIC

- D.C. JAYASURIYA (THAILAND)

All attention of medical scientists and social scientists is concentrated on AIDS. More so because AIDS pandemic has focussed attention on the social implication of the disease. While scientists are wrestling with devising an antidote to the HIV virus, social and behavioural interventions and strategies have to be given equal measure of thrust by the governments, especially in the Asian region.

* The paper, **'Role of Social Scientists in the AIDS Pandemic'** put forth the view of approaching the AIDS essentially from a non-medical and non-clinical perspective also. The age group generally affected by HIV and AIDS is an important social and demographic cohort between 15 to 49 years of age. HIV tends to strike men and women going through key life cycle events, such as first sexual experience, family formation, employment and participation in the national development process. Despite all the impressive gains in medical, nuclear, computer and related fields of scientific and technological endeavour, our knowledge of the dynamics of sexual behaviour, intra-venous drug use and the propensity to high-risk behaviour is still relatively rudimentary. Propensity of policy makers to assess the magnitude of the problem only within the medical area and lackadaisical political response to the disease has eclipsed the social aspects and the possible social responses to AIDS.

Within the area of behavioural and life style changes, there are many social concerns and interventions which need to be spelled out and reflected in any comprehensive model which looks beyond the issues of medicalization and stigmatization. It is not surprising that there are many conceptual and methodological problems which need to be addressed by social scientists. AIDS-related social studies are beset with constraints which are inherent in the social norms and accepted social behaviour patterns. And moreover any common concepts are difficult to formulate because different concepts prevail in different societies. Social science studies in this area have to contend with lack of recent base-line data or access to empirically tested research techniques. The lack of trained personnel is a formidable problem also and more so in developing countries. To overcome these hurdles there is a need to develop reliable research instruments and sound research studies which will serve as becon-lights for the policy-makers in their effort to control and prevent AIDS pandemic.

* The Presentation on **'Epidemiological Aspects of AIDS'** gave an incisive assessment of AIDS pandemic in developed and developing countries. There is a possibility of large-scale spread of the disease in Africa and Asia. The susceptibe population would be mothers and their offspring. Lack of blood-testing facilities would compound the problem further. The measures checking this tide have to be two-fold. The clinical measures have to go hand in glove with raising social consciousness among the potential target groups and people in general about the likely causes of this disease.

HEME - 5

PLENARY SESSION

CHAIRMAN : **PROF. T.N. MADAN**

RAPPORTEUR: **DR. GITA BAMEZAI**

The open session on 18th March, 1992 was marked by vigorous ebate on multi-disciplinary issues relating to Health. It nabled participants to share and exchange ideas and views with ach other. They reached consensus on the following point:

. A tie-up between social sciences and medical sciences should e emphasised. Health has largely been 'medicalized' with social cience research efforts marginalized by perfunctory studies. here is a growing need to build up multi-disciplinary research n social science and medicine to fill up the gaps in achieving he goal of HFA. The Matlab MCH experiment in Bangladesh is an vidence of successful use of social science research tools in mproving the health status of the people inspite of the negative nfluence of poverty and lack of resources.

. Social action and Community involvement can have the desired esults in improving the health situation at the grass-roots evel. The focus and attention of HFA has come to be riveted on rimary health care. Social science research can provide the mpetus in collection of reliable information and primary data at he grass-roots level without which any effective reach is mpossible. Most of the countries in the region, especially hailand, have evolved an internal information set up to gear up ealth system through data banks and networking. But among the ther countries this initiative is not forthcoming.

. A networking system, especially within the Asian region, was ooted by the participants. This requires a forum for sharing nformation on health systems and research, initiating exchange rogrammes and training facilities among the member countries.

. Cross-cultural studies would support and augment the ongoing esearch in individual countries. Thus most of the countries of he region have similar demographic profiles and health ndicators like IMR, Birth Rate, and MCH Status. Many nagging ealth issues can be resolved through such initiatives and in the ong term bring about a better understanding among the countries.

An important issue which is gaining recognition in the ealth systems is the matter of privatization. In the Asian egion major support to health infrastructure and system is rovided by the government. But an important ancillary to this ffort is the service support provided by private practitioners

who provide medical-care not only in urban areas but are also equally active in towns and villages. A partnership between Government and private medicare will ensure a more viable delivery system especially at the PHC level and down below.

6. Social Science strategies should be used for creating the appropriate social climate for involving the community in the prevention and treatment of communicable diseases, especially in controlling the AIDS pandemic. It is widely established that apart from clinical treatment social treatment of AIDS is paramount and the viable approach.

CLOSING SESSION

- **GENERAL REMARKS** : PROF. T.N. MADAN

- **VALEDICTORY SPEECH** : DR. KARAN SINGH

- **CHIEF RAPPORTEUR** : MRS. SUSHEELA BHAN

- **VOTE OF THANKS** : PROF. P.L. TRAKROO

VALEDICTORY SESSION

The valedictory function was presided over by Dr. Karan Singh. He is a well-known intellectual and politician and at one time was the Minister for Health in Mrs. Indira Gandhi's Cabinet (1972-77). Dr. J.P. Gupta, Director, NIHFW welcomed Dr. Karan Singh on the occasion.

Dr. Karan Singh said that there was a need to treat the subject of health in a wider context. Health is not a state of non-illness but the entire life-spectrum from conception to death should engage our attention in order to improve the quality of life at all levels. One of the hurdles in achieving HFA is the burdegeoning population. He emphasised the need to streamline the Family Planning Programme which had received a setback in late seventies. There is the need to check the exponential rate of population growth which has swelled from 361 millions to 860 millions today. More than new policy, the implementation machinery has to be made more effective. Reversing an earlier statement of his, namely 'development is the best contraceptive', Dr. Singh said that, 'today contraception is the best development', thereby stressing that priorities of the family planning programme have to be shifted to service delivery.

Dr. Karan Singh emphasised that the scope of the MCH care has to be made more comprehensive and rationalistic. Nutritional inputs have to be provided for at critical junctures - before birth, during delivery and, subsequently, to the mother as well to the infant. But even where nutritional inputs are provided for, they are sporadic and not streamlined for any effective result.

Dr. Singh made a plea for incorporating health components in the educational system as well. Wherever a mid-day meal programme in schools is running, a medical check-up should form a part of the package. This wholesome programme should be promoted in schools especially in rural areas and small towns where access to medical facilities is restricted.

Evaluating health in purely physical terms, Dr. Karan Singh said, is not enough. He spoke about the spiritual dimension of health, which, if neglected, leaves a critical void. Moving towards a holistic paradigm means imbibing a nobel spirit in a healthy body.

Prof. T.N. Madan, Institute of Economic Growth, Delhi, spoke about the activities under the auspices of the Journal of Social Science and Medicine. Two earlier conferences held in South America and later in Africa have received good response both from social experts and medical professionals. Dr. Susheela Bhan, Executive Director of ICSSR, read out the report of the different sessions. Prof. P.L. Trakroo thanked the guests and the delegates to the Seminar.

APPENDICES I, II AND III

APPENDIX 1

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APPENDIX II

SOCIAL DIMENSIONS OF HEALTH CARE AND HEALTH POLICY

Keynote Address

Professor S.C. Dube

16th March, 1992

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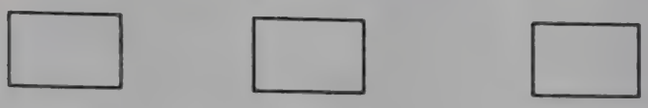
In recognition of the importance of health for human well being and development, an ambitious plan of Health for All has been initiated under the auspices of the UN and its associated organizations. The magnitude of the problem is mind-boggling, not so much in terms of the numbers to be brought under the programme, but in terms of the many intangibles and imponderables underlying the complex interplay of social and psychological factors in diverse cultural settings. The nexus between health and culture is important: to ignore the social dimensions of health is like jumping in the dark in an alien and uncharted territory. Such a mindless adventure must be avoided.



It is necessary to locate the discourse on health within the wider discourse on development. For this a quick look at the changing global scenario and related paradigmatic shifts in the thinking on development is essential. The new contexts have a significant bearing on policies governing health care.

The last two years of the 1980s and the first two years of the 1990s may well go down in history as years of climatic change. The dramatic upheavals that took place in these years have left the contemporary generation gasping because of their lightning speed and complex ramifications.

The world today is not what it was a decade back, but its configurations still have several enigmatic aspects. One can not foresee how it will shape itself. There are some signs of hope; the danger of a nuclear holocaust has receded somewhat, and if things go well cold war between the super powers may become an unpleasant memory of the past. But it is necessary to avoid premature and excessive optimism. The prospects of a stable world order and global peace still remain dim. No solutions are in sight for many intractable problems. The world system continues to be fragile. No mechanisms have been evolved to hold in check regional conflicts that erupt from time to time and have the fury and destructive potential of limited short duration wars. Terrorist violence - national and international - has acquired lethal dimensions. The state apparatus apparently is not able to contain it; it is, in fact, spreading like a virus against which no known antidote works. The quest for peace, thus, remains elusive. And peace cannot be understood only as absence of war. There is turbulence in the atmosphere because of a convoluted want-get ratio. The distribution and consumption of resources is uneven; a few highly industrialized countries corner a disproportionately large share for themselves. In consequence, the revolution of rising expectations has failed to deliver the desired results and the less developed countries are experiencing a nightmare of frustrations. Pervasive discontent and disaffection have resulted in a credibility gap and a crisis of legitimacy for the state system. Having to address itself to order goals and selectively to output goals, the state finds

itself unable to attend to the minutiae of development problems that concern the different strata of society, particularly the disadvantaged poor. Welfare goals get neglected in the process.

The dominant paradigms of development have undergone major shifts. The Western or Capitalist Model of development, though it has been revived, had lost much of its cocky pertness as it had failed to prove itself in the Third World context. It was under relentless criticism from the leftists as well as the alternativists. The invisible hand in action worked more favourably for the advantaged segment of society; from the trickle down the poor got too little and too late. It was evident that development could not be considered only as the raising of output by making careful and critical inputs. The Communist Manifesto also did not prove to be a self-fulfilling prophecy. The people could not live on revolutionary rhetoric alone; after decades of deprivation they wanted more of material goods. The revolutionary regimes could not provide these as their handling of the economic situation was inept and inefficient. Those disenchanted with these models were searching for new development alternatives. In the universe of discourse new concepts moved centre stage. Important among them were "human-centred development", "basic needs", and "quality of life". Consideration of health was central to all the three concepts. Certain additional concerns also emerged. Environment was one: pollution had to be avoided and the quality of environment improved. Unless this was done the threat to human survival would be greater from this source than it has been through war. Energy was another. It was to be conserved and alternative sources of it had to be found. Feminist assertions necessitated careful appraisal of development goals and strategies, to ensure that they did not adversely affect the equality of status and opportunities for women. Discrimination against women in diet and medicare had to be ended. The notion of cultural autonomy was also legitimated. Development was expected to permit cultural choices that were not subordinate to the `development imperatives.' It is against such a scenario that we should have contemplated the social dimensions of health care and health policy.

For the developing world these considerations are still valid, but the situation has changed. In the new scenario the logic of the market place prevails. One hears a great deal about intellectual property rights, copyright, and patents. The fear of invoking special 301 unnerves the developing countries, who must submit to the dictates of one commanding power or face severe reprisals. Contemplate, for a moment, the predicament of the poor countries in a situation where even in the world's richest country - the United States millions of people can not afford medical care because of their poverty and artificially jacked up prices. Currently there is a raging controversy regarding two drugs for dissolving clots in the arteris or, in plain words, for the treatment of heart disorders. Streptokinase at $200 per dose was as effective, if not more, as TPA at $2,200 per dose. The latter has been expensively advertised and physicians have almost

een blackmailed into prescribing it in preference to the cheaper ubstitute. The logic appears to be: the more expensive the rug, the more effective it is. In consequence, Streptokinase ad to be priced up at $300 per dose to cover additional arketing costs. In the end TPA is likely to emerge the winner, lthough there are good reasons to believe that its alleged uperiority rests on fake trials and manipulated results. Other rugs may follow the same course. How do the poor cope with such situation?



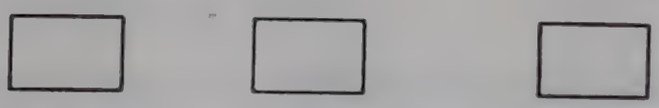
Health has to be seen as a basic need and an essential component of the quality of life. It is an intrinsic value and goal. In addition, it also has important instrumental functions. If health is dealt with gingerly in development planning, and treated as an expensive overhead, the attainment of several important development objectives in other related areas may be affected. Health, for example, has a direct bearing on productivity. In the same way, health and education have to be understood as interacting and mutually reinforcing subsystems. Education creates a heightened awareness of health and health care. Deficiency in protein intake in the earlier years of life and continuous illness can seriously impair the mental capacity of a child and his or her potential as a learner. Education can promote the conception of a balanced diet, awareness of environmental sanitation, and ideas of social hygiene. Education and health consciousness together will contribute to planned population growth. Meaningful development planning, thus, has to make adequate provision for health care. In this context, "health" and "health care" have to be defined broadly, for they include, besides preventive and curative medicine, nutrition and provision of potable water, environmental sanitation, social hygiene, rest and recreation, and much else.

Health care packages have to be culturally contextualized. What makes for good health is as much a matter of scientific understanding of nutrition, hygiene, and causation of disease as of cultural orientation to health and illness. In the Indian context some diseases may be attributed to one's errors of commission and omission in past lives, some to divine wrath, some to supernatural malevolence, and some to natural causes. These deep-seated beliefs persist even after years of education and exposure to modern scientific ideas. Even physicians and surgeons trained in modern medicine carry some shreds of these beliefs. Then there is the classification of foods into "hot" and "cold" categories. Some practitioners of modern medicine are also known to recommend hot or cold foods according to the nature of the disease being treated, for they tacitly recognize this distinction. We have also to consider some cultural practices widely prevalent in the area of health care, especially the care of the ill. Should a new born not be given water for the first three months, even if the birth has taken place in the summer

months of April, May or June? Must the mother of a new born be fed with high fat and high sugar concoctions that are supposed to restore strength to her body? The care of those suffering from leprosy, tuberculosis, epilepsy, hysteria, jaundice, measles, chicken pox, small pox, and many similar diseases is culturally conditioned. Can the prevalent notions be altered without a direct confrontation with culture?

As important as the health care package is the health delivery system. Do messages of preventive and social medicine reach the common people? How do they manage the culture-rooted reactions which such messages produce? Is the provision for curative medicine adequate? Our delivery systems often falter and the provision for curative medicine is woefully inadequate. This is not likely to promote confidence in modern medicine. Every failure on this front leads to return to common beliefs, fatalism, and to nostrums more readily available.

A sound development policy has to adopt a holistic view of human needs; while planning for them their interconnections cannot be ignored. A close watch on emerging trends is needed to identify unintended consequences, goal transfers, and disharmonic effects so that corrective action may be taken when required. Health is not an isolate, nor is it isolable. Health objectives have to be enmeshed and harmonized with the entire range of development goals - raising productivity and GNP, food security, quality of environment, education,housing, and so forth. Weakness in any one is likely to have an adverse effect on all others.



The key issues in the area of mother and child care hinge on the explicit and implicit assumptions regarding the status and roles of women in society. Gender discrimination is an ugly aspect of our social reality-a fact that cannot be denied, rationalized, or wished away. Fragments from holy books lauding the women to the skies and awesome profiles of her being the embodiment of power notwithstanding, durable stereotypes present her as weak, fickle, and easily defiled. Her role in biological and social reproduction is undervalued and she never gets the credit that she deserves for her heavy domestic chores as well as contribution to the economy. Female infanticide was and continues to be practised in some groups. An advance in medical science - amniocentesis - has now facilitated this practice, and the figures of female foeticide are alarming. In 1984, in the city of Bombay alone there were as many as 40,000 cases of female foeticide. Many more female children die of callous neglect and deliberate indifference. According to a dependable estimate, in India 300,000 more girls than boys die in infancy. The nutritional profile of women compares unfavourably with that of men in a high proportion of Indian families. Frequent pregnancies, abortions, and child births leave their imprint on

women's health. They carry heavy workload even during periods of impaired health. They have little rest and recreation. Discrimination extends even to education and thus to economic opportunities. These factors inhibit their productive participation in wider social and economic spheres and blunt the articulation of their creative potential. As domestic drudges they cannot even become effective mothers. The pampered boys as well as the neglected girls both lose a great deal as a result of the forced inadequacy of the mother.

Can something be done? A massive programme of consciousness raising and an added impetus to female education is indicated as a long-range programme of human resource development. But we should not expect any dramatic results from it in the short run. Changes in this sphere need at least three generations to take firm roots and get stabilized.

In the meantime the reach of mother and child care services will have to be extended and their content improved qualitatively. A programme of supplementary nutrition for the pregnant mothers will have to be devised and implemented. The experimental and tentative nature of such projects suggests that their foundation is till shaky. Cultural factors come in the way. Who will cook? Food cooked by those of the lower castes may not be acceptable to the upper castes. What shall be the constituents of the food supplements? Eggs, Fish, and even enriched bread may be rejected by some groups. Will it do if raw ingredients from a carefully worked out inventory are supplied to the beneficiary? In most cases not, for one can count on the self-sacrificing Indian and Asian woman to feed them to her children and husband. Let us pause and think how we can make these programmes work.

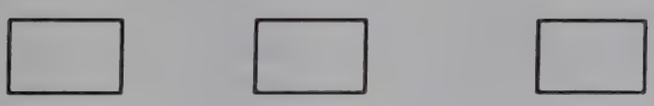
Immunization programmes have been splashed on the media; in their TV format they generate a sense of euphoria. But let us ask: How wide is their reach? How effective is their communication strategy? And how dependable is their schedule? As of today several pockets even in urban areas remain untouched. What, then, is the situation in remote tribal settlements and distant villages? In several areas the programmes have been greeted with apathy,indifference, and even hostility. Communication support appears to have been inadequate and ineffective. What we need is more interpersonal communication and peer group intervention in support of the programme. Bureaucratic hassles, irregular visits, and absence of timely supplies are not calculated to build confidence in a hesitant and suspicious clientele.

Rapid urbanization is a feature as well as an outcome of modernization. A conjunction of several factors and forces has created a situation in which a pull factor operates in the urban

entres and a push factor operates in the rural countryside. rban centres have industries requiring labour as will as other mployment opportunities. Prospects of finding work brings ordes of village people into the cities; they are attracted also y the "pleasures" of urban life, without the constraints haracteristic of village life. Problems arise because the ntire process is unplanned and unregulated. Industries, even if hey are initially set in the urban periphery, are engulfed by rban growth. They throw up poisonous fumes and other toxic astes. Automobiles contribute to atmospheric and noise ollution. Congested areas are without lungs as greenry is the irst casuality of unplanned urbanization. Few urban centres ave adequate sewerage and other facilities for the disposal of uman waste. Arrangements for the disposal of garbage are also ot very satisfactory. This kind of setting is not very ropitious for the promotion of health.

The situation is compounded by the flow of immigrants from he country-side into the urban centre. Megacities, and indeed ll large cities, in the developing countries have to face the roblem of squatters and pavement dwellers. All of them have arge colonies of people living in make shifts dwellings. The ity cannot provide even minimal civic amenities to this opulation. It lives in squalor, without toilet facilities and ven regular supply of water. Drink and drugs, crime and vice, mbling and prostitution become features of the lives of this egment. Lack of hygiene and malnutrition brings in a number of lments and diseases. Sexually transmitted diseases are common. India, outbreak of gastro-enteritis is an annual feature in uatter colonies.

The solutions to the problem are obvious, but its magnitude such that little can be done. Inflow has to be regulated, ttlements have to be planned, basic sanitation has to be ovided, and a purposive health education programme has to be plemented. Immunization will have to be taken to the orsteps. The task is immense, but ways have to be found to al with the health hazards implicit in the urban culture of verty.



The word "privatization" appears to have acquired a magical ality. In the most recent update of the Arbian Nights of onomic development one only has to substitute "privatization" r the conventional "sesame" to get all doors open. Much of the iticism of the public sector- its inaptitude, inefficiency, and oth - is valid, but that by itself is not enough to absolve the ivate sector from its age-old guilt of greed and exploitation. the health care field, however, "privatization" is not a new enomenon. It has always been there in one form or the other, en in several forms. Besides home remedies and folk nostrums, has the choice of a variety of therapies ranging from the

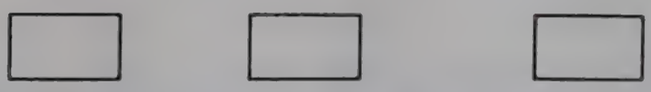
inistrations of magicians and medicine-men to faith healers and godmen to diverse recognized systems of medicine, indigenous and modern, and a wide variety in between. The institution of the old and faithful family physician continues and most people turn to it for their common health problems. Most government run dispensaries and hospitals permit private practice to their physicians and surgeons and it is commonly believed that entering the hospital via the private chamber of a physician or surgeon secures quicker entry and better treatment. Specialists-physicians and surgeons as well as pathologists and radiologists-have a flourishing practice. It is well known that many of them form a nexus and aid and abet one another at the cost of patients. There are far too many unnecessary tests, wasteful medication, and even fake surgeries. Medical ethics take a back seat; patients become helpless victims of the urscrupulous greed of the healers. Nursing homes and maternity homes have been in existence for several decades and have apparently been doing well. What has highlighted the privatization factor is the setting up of five star medical facilities with hightech diagnostic aids. But these evidently serve only those who have the wherewithal to take advantage of them. The poor are neglected by private hospitals, which obtain land at concessional prices and import duty exemptions, on the condition that they will offer free treatment to the poor. The rich could always go abroad for treatment. Powerful politicians and senior bureaucrats joined their ranks as they were financially supported by the state to undergo specialized surgery and treatment. At one point of time a coronary bypass surgery in Houston or treatment at Johns Hopkins had become a status symbol. Now these facilities have come to India. Their costs are lower than those of foreign hospitals, but they are yet way beyond the capacity of the average Indian. How many can afford a coronary bypass package at Rs. 75,000,which does not cover possible post-surgical complications? A few state run hospitals also offer such specialized surgery, but they have long waiting lists and even they require payment for disposables, which in the case of heart surgery may be, at the lowest level, of the order of Rs. 25-30,000.

The harsh fact is that even ultra sound and CT scan are beyond the financial capability of the poor and the lower middle class. Private medicare is there to stay; the trend cannot be reversed. But its commercialization has to be held in check. It is excessively expensive, has skewed distribution, and if left unregulated can lead to unethical over-medication and non-essential surgery. Those will relatively modest resources also need clean and efficient hospitalization at affordable prices. How do we ensure this? And what of the poor? Must they be condemned to pain and suffering and to a slow and lingering death? Can they be assured access to the miracles of medical science by social insurance pegged to their capacity to pay?

The magic of the market place has worked to the detriment of the sick globally, but the less developed countries feel the pinch all the more. Drugs banned and discarded by the advanced

countries as injurious are off-loaded on them with total unconcern for consequences. Expensive but ineffective even harmful combined drug formulation are freely sold. Dangerous drugs, without precautionary warnings and contra-indications, can be bought off the counter. Markets are saturated with a wide range of restoratives, tonics, and vitalizers, which are all medicinally useless. The pressure of multinationals makes it difficult to sell basic medicines under generic names; identical drugs are sold under prestigious brand names at exhorbitant prices, The consumer everywhere has to pay, besides production and R&D costs, for heavy advertisement spending. Monopoly manufacturers are known to have withheld inexpensive but effective substitutes until they have recovered their investment, with profit, in earlier drugs. These trends tie up the medicare services in knots.

The dreaded AIDS has caused a global scare. Its spread can be attributed to the breakdown of the norms of sexual ethics and the prevalence of an ethos of permissiveness in what was perhaps the most intimate and private domain of life. Permissiveness and experimental sex, thus, are mainly behind this fatal disorder. But we cannot write if off as divine retribution for breach of sacred moral codes, as innocent lives are also affected by it through transfusion of contaminated blood or use of infected hypodermic needless. The care of infected patients also poses serious problems. There is no known cure for the disease. Thus, to control its spread massive education in sex hygiene is essential. Blood used for transfusion must also be checked carefully. Those testing positive for AIDS must be educated regarding the implications of their conditions and guided to reorganize their way of life. Cases likely to infect others should be isolated and kept under watch. Return to a sane sex life is of essence and to this end social consciousness has to be awakened.



So long as poverty and illiteracy persist only limited gains can be registered in the field of health care. The accent has to be on health education and preventive medicine, including immunization. For this youth power has to be energized and voluntary action groups activated. Barefoot doctors, inducted in a cavalier manner, can do more harm than good. The scheme of access to a smorgasbord of medical systems also has not worked well. Both need better conceptualization and implementation. The malaise of the medicare systems are known, but we have lacked the will to attempt radical therapy. Vested interests often block effective action. This forces us to make notional reforms and treat only some of the symptoms. The situation is too grim to permit such prevarication.

APPENDIX III

PROGRAMME

Monday, the 16th March, 1992

	Activity		Venue
-1000 hrs.	Registration		Registration Counter
-1100 hrs.	Inaugural Function	Chief Guest SH. K.K. MATHUR, SECRETARY, DEPTT. OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVT. OF INDIA.	Ground Floor Hall Teaching Block
-1200 hrs.	Key-Note Address by Prof. S.C. Dube	Chairman Dr. J.P. Gupta Rapporteur Dr. Gita Bomezai	Ground Floor Hall Teaching Block
-1730 hrs.	Maternal and Child Health, Presentation of Papers	Chairperson Mrs. Rami Chhabra Rapporteur Dr. H.H. Simon	First Floor Teaching Block

1. Tea : 1100-1130 hrs.
   1530-1600 hrs.

   Lunch : 1330-1430 hrs.

SOCIAL ENGAGEMENTS

2. Dinner : 2000 hrs. Venue: India International Centre
   Lodhi Estate
   New Delhi

Tuesday, 17th March, 1992

	Activity		Venue
330 hrs.	Urban Health Services: Issues Presentation of Papers	Chairperson Dr. N.S. Deodhar Rapporteur Dr. S. Bhatnagar	First Floor Teaching Block
730 hrs.	Interface between Private, Voluntary and Government Health Services	Chairman Dr. Santhat Sermsri	First Floor Teaching Block
	Presentation of Papers	Rapporteur Dr. R.N. Gupta	

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1. Tea : 1100-1130 hrs.
   : 1530-1600 hrs.

   Lunch : 1330-1430 hrs.

Wednesday, the 18th March, 1992

Time	Activity		Venue
0900-1100 hrs.	AIDS: A Social Perspective by D.C. Jayasuriya, UNESCO, Bangkok	Chairman Dr. S.P. Tripathi Rapporteur Dr. S. Bhatnagar	First floor Teaching Block
1130-1530 hrs.	Open Session	Chairman Prof. T.N. Madan Rapporteur Dr. Gita Bomezai	First Floor Teaching Block
1530-1630 hrs.	Valedictory Function	Chief Guest Dr. Karan Singh	Ground Floor Teaching Hall

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Tea : 1100-1130 hrs.
1630-1700 hrs.

Lunch : 1330-1430 hrs.